

FILED JUN 13 1944
Registration District No. 104

Primary Registration District No. 5111

Registrar's No. 1

1. PLACE OF DEATH:

(a) County BOLLINGER
(b) City or town RURAL LIBERTY TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether)
In this community 9 YEARS
years, months or days

3. (a) PRINT FULL NAME LENA GALLOWAY

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MELVIN GALLOWAY 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Feb. 22 1900
(Month) (Day) (Year)

8. AGE: Years 44 Months 2 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace BOLLINGER Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation H.W.F.

11. Industry or business _____

MOTHER FATHER { 12. Name ED. KEY
13. Birthplace 11 (City, town, or county) (State or foreign country)
14. Maiden name LETTA ATCHISON
15. Birthplace 9 (City, town, or county) (State or foreign country)

16. (a) Informant MELVIN GALLOWAY
(b) Address HANN, MO.
17. (a) BURIAL (b) Date thereof MAY 19 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation UNION HILL CEM.

18. (a) Signature of funeral director None
(b) Address _____
19. (a) 5/19/44 (b) Mrs. Geneva Graham
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County BOLLINGER
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. NEAR HANN, MO. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 18 year 1944 hour 11:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death No medical attention
Probably coronary occlusion
Due to _____

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) 94a

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury Coroner
23. Signature J. C. Graham (M.D. or other)
Address Luttwille, Mo. Date signed 5/19/44

RECEIVED

District Health Officer No. 4
District File Number 644-3899
Date Filed 6-6-44

MAY 15 1953

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Not Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.